STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G286	A. BUILDING _____ B. WING _____	R 03/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE, INC GREY FOX RUN GROUP HOME	**312 GREY FOX RUN NEWPORT, NC 28570**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A revisit was conducted on 3/1/2021 for all previous deficiencies cited on 1/07/2020. The following deficiencies were corrected, W125, W369 and W418. There was new non-compliance at W382 further and the facility remained out of compliance in W249.	W 000		
{W 249}	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, review and staff interviews, the facility failed to ensure each client received a continuous active treatment program consisting of needed interventions and services identified in the individual program plan (IPP) in the area of adaptive orthotic equipment for 1 of 3 audit clients (#2). The findings is: During observations in the home on 3/1/21 at 12:35 PM, client #2 sat in a recliner chair in the living room and would randomly remove his socks and kick off his high top shoes. Each time, the qualified intellectual developmental professional 1 (QIDP#1) physically assisted him to put on shoes and socks. The QIDP#1 was not observed handling any orthotic equipment when she put the	{W 249}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{W 249}	Continued From page 1 shoes on client #2's feet. An additional observation on 3/1/21 at 3:05 PM, client #2 sat in the recliner with bare feet. Staff C took client #2 into his room to gather his footwear. Review on 3/1/21 of a Physical Therapy (PT) Evaluation dated 1/20/20 revealed that client #2 had a 3/8" limb length discrepancy and recommended an off shelf insert to improve distal biomechanical support. Review on 3/1/21 of the IPP dated on 11/3/2020 revealed that client #2 ambulated independently with a limp and the physical therapist recommended that inserts be worn in high top shoes. Interview on 3/1/21 with staff C revealed that when she assisted client #2 with putting on his shoes, she only found shoes and socks on his bed. She did not have any inserts to put into his shoes and was unaware that he had to wear them. Interview on 3/1/21 with the habilitation coordinator revealed that client #2 was only supposed to wear compressed socks and high top shoes. She was not aware of an order for orthotics. Interview on 3/1/21 with the QIDP#1 revealed that she missed the PT's evaluation when writing the current IPP. She indicated that she was under the impression that client #2 only had to wear compressed socks and high top shoes.	{W 249}		
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2)	W 382		

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W 382	Continued From page 2 The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to secure medications, when staff was not present. This had the potential to affect all clients. The finding is: During medication administration observation in the home on 3/1/21 at 3:35 pm, staff C stepped out of the med room, with the medication cabinets unlocked and leaving the door ajar. Staff C walked into the adjacent dining area, to tap client #6 on the shoulder, so that he would get up for med pass. Staff C helped client #6 walk to the med room; she did not need her key to open the door. A sign taped to the med room door read: "Medication Room must be secured when staff are not in the room. Thank you" Interview on 3/1/21 with staff C revealed that she thought she had pulled the door to the med room closed when she left to get client #6. Interview on 3/1/21 with the qualified intellectual disability professional #1 (QIDP#1) revealed that she expected staff to lock the door to the med room, if staff must leave to get the client.	W 382		